



Texas Department of Insurance

Division of Workers' Comp

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

USMD HOSPITAL ARLINGTON
801 WEST I 20
ARLINGTON TX 76017

Respondent Name

AMERICAN HOME ASSURANCE COMPANY

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-08-4993-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are requesting reconsideration on the above date of service because the implants were underpaid according to: Rule 134.401 [(c)] (4) (A)..."

Amount in Dispute: \$14,952.30

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "AIG reimbursed \$7,849.40 for the kit extension set and leads for the implants. The stimulator charge was not reimbursed because it is not for this patient Perry Moor. Perry Moore was in the hospital 08/16/07 through 08/23/07. The order date on the invoice is 09/14/07. Perry Moore was at home recovering on 09/14/07."

Response Submitted by: AIG Insurance Services, Inc., 8144 Walnut Hill Lane Suite 1500, Dallas TX 75231

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
August 16, 2007 and August 23, 2007	Outpatient Surgery	\$14,952.30	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 TexReg 3561, requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation

health care network shall be made in accordance with subsection §134.1(d) which states that “Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available.”

3. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
4. This request for medical fee dispute resolution was received by the Division on March 31, 2008.
5. The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 1 – (42) Charges exceed our fee schedule or maximum allowable amount.
 - 2 – (150) Payment adjusted because the payer deems the information submitted does not support this level of service.

Findings

1. The requestor's position statement asks for reimbursement in accordance with 28 Texas Administrative Code §134.401(c)(4)(A). However, the Division notes that the Division's former *Acute Care Inpatient Hospital Fee Guideline* is not applicable to the services in this dispute; per §134.401(a)(4), outpatient surgical care is not covered by that guideline and shall be reimbursed at a fair and reasonable rate until the issuance of a fee guideline addressing those specific types of reimbursement. Review of box 4 on the provider's medical bill finds that the type of service code billed was 131 indicating outpatient services. No documentation was found to support that the length of stay exceeded 23 hours. Review of the submitted information finds that the services were outpatient services and therefore the applicable rule for reimbursement is found in former Division rule at 28 Texas Administrative Code §134.1, effective May 2, 2006, 31 TexReg 3561, which requires that, in the absence of an applicable fee guideline, reimbursement for health care not provided through a workers' compensation health care network shall be made in accordance with subsection §134.1(d) which states that “Fair and reasonable reimbursement: (1) is consistent with the criteria of Labor Code §413.011; (2) ensures that similar procedures provided in similar circumstances receive similar reimbursement; and (3) is based on nationally recognized published studies, published Division medical dispute decisions, and values assigned for services involving similar work and resource commitments, if available.”
2. 28 Texas Administrative Code §133.307(c)(2)(E), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include “a copy of all applicable medical records specific to the dates of service in dispute.” Review of the submitted documentation finds that the requestor has not provided copies of any medical records pertinent to the services in dispute. The requestor did not submit a copy of the operative report, anesthesia record, nursing notes, post-operative care record, or other pertinent medical records sufficient to support the services in dispute. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(E).
3. 28 Texas Administrative Code §133.307(c)(2)(F)(i), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include “a description of the health care for which payment is in dispute.” Review of the submitted documentation finds that the requestor has not provided a description of the health care for which payment is in dispute. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(i).
4. 28 Texas Administrative Code §133.307(c)(2)(F)(iv), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires that the request shall include a position statement of the disputed issue(s) that shall include “how the submitted documentation supports the requestor position for each disputed fee issue.” Review of the requestor's documentation finds that the requestor has not discussed how the submitted documentation supports the requestor position for each disputed fee issue. The Division concludes that the requestor has not met the requirements of §133.307(c)(2)(F)(iv).
5. 28 Texas Administrative Code §133.307(c)(2)(G), effective December 31, 2006, 31 TexReg 10314, applicable to disputes filed on or after January 15, 2007, requires the requestor to provide “documentation that discusses, demonstrates, and justifies that the amount being sought is a fair and reasonable rate of reimbursement in accordance with §134.1 of this title (relating to Medical Reimbursement) when the dispute involves health care for which the Division has not established a maximum allowable reimbursement (MAR), as applicable.” Review of the submitted documentation finds that:
 - The requestor's position statement asserts that “the implants were underpaid according to: Rule 134.401

[(c)] (4) (A)..."

- As stated above, §134.401(c)(4)(A) is not applicable to the services in dispute. The applicable rule is former 28 Texas Administrative Code §134.1.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not submit nationally recognized published studies or documentation of values assigned for services involving similar work and resource commitments to support the requested reimbursement.
- The requestor did not support that payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307. The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the services in dispute.

Authorized Signature

Signature

Grayson Richardson
Medical Fee Dispute Resolution Officer

September 6, 2011
Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Texas Administrative Code §148.3(c).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.